ADJUSTING HOSPITAL INPATIENT PAYMENT SYSTEMS FOR COVID-19

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Summary: All countries in Europe will have to find solutions to protect hospitals from revenue shortfalls and to adequately reimburse for COVID-19-related costs of care. This article reports on changes to hospital payment systems in Belgium, Bulgaria, the Czech Republic, Finland, France, Germany, Israel, Poland, Romania, Switzerland, and the United Kingdom (England). Hospitals in these countries are paid for treating COVID-19 patients using the usual system, modified Diagnosis Related Groups or new mechanisms. In many countries, hospitals receive their usual budgets or new money to compensate for revenue shortfalls. Only a few countries are paying non-contracted providers.

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Introduction to hospital payments and COVID-19

Since the emergence of COVID-19, health systems worldwide have had to respond to a range of different challenges. With a considerable proportion of COVID-19 patients requiring hospitalisation, hospitals were at the forefront of the pandemic in many countries. Hospitals have had to cope with the influx of COVID-19 patients, or with the consequences of preparing hospitals for an anticipated influx. Hospital services have been restructured, intensive care unit (ICU) capacity expanded, elective admissions cancelled, and patient pathways reorganised.

All of these challenges have had implications for hospital financing. First, the costs of care related to COVID-19 patients can be substantial and these costs could not be anticipated at the time when hospital budgets or hospital payments were determined. In addition, hospitals have had to invest in purchasing new ventilators or protective personal equipment (PPE) to prepare for COVID-19 patients.

Second, in many countries with activity-based payment systems, hospitals have experienced revenue shortfalls because they had to cancel elective procedures or because patients avoided being admitted to hospitals. Third, non-contracted acute care facilities (including private hospitals) have had to be compensated for the services provided.

This article aims to support policymakers across countries who have to respond
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to these challenges by taking decisions about the payment of hospitals: Should payment be adjusted to reflect the costs of COVID-19? Should payment be kept the same irrespective of activity to compensate for revenue shortfalls? What mechanisms can be used to channel financial resources to non-contracted providers? We identified hospital payment system adjustments in countries reporting to the COVID-19 Health System Response Monitor (HSRM), then checked with national experts about further changes (up until the end of July 2020) to understand whether and how countries have changed their hospital payment systems in response to COVID-19. The paper focuses on a selection of countries including: Belgium, Bulgaria, the Czech Republic, Finland, France, Germany, Israel, Poland, Romania, Switzerland, and the United Kingdom (England) but also draws on examples from Cyprus, Malta, Slovakia, and Slovenia, where relevant.

In many countries, hospitals receive their usual budgets or new money to compensate for revenue shortfalls

In many countries, compensating revenue shortfalls resulting from the interruption of usual activities has been a more important problem than paying for COVID-19 patients. Figure 1 shows that numerous countries have responded to these revenue shortfalls through a range of approaches, which differ considerably, depending on the pre-existing payment system, amongst other factors.

In Poland, where most hospitals receive a Diagnosis-related group (DRG)-based budget (determined by the previous year’s activity), hospitals in the public hospital network continue to receive their usual monthly instalments despite considerably reduced activity. Hospitals outside of the network can apply to receive monthly instalments for contracted services under the assumption that these will be provided later during the year. Similarly, in the Czech Republic and Slovenia, hospitals continue to receive their regular monthly instalments of a DRG-based budget despite a substantial decrease of activity. Under normal circumstances, this would affect the settlement of the annual bill at the end of the year.

However, in Czechia, a new regulation has specified that hospitals can keep the full budget as long as their 2020 activity is between 79% and 82% of their 2018 activity (depending on the number of COVID-19 patients treated). If hospitals stay below this level, their monthly instalments in 2021 will be adjusted accordingly, while they may receive additional payments for services provided beyond the 79–82%. In Slovenia, a decision has not yet been taken on the settlement of the annual bill. In Israel, where hospitals are mostly paid based on a mix of DRG-like payments and per diems, hospitals always have a guaranteed minimum income of 95% of the previous year’s income, which protects them from income loss – also in the case of COVID-19.
Box 1: Substantial support for hospitals: Germany’s Hospital Relief Act

In March 2020, the German government passed the Hospital Relief Act to provide financial support for hospitals with the aims to: (1) compensate revenue shortfalls due to decreased admissions; (2) fund increased treatment capacities; (3) cover additional expenditure related to COVID-19; and (4) provide hospitals with financial leeway.

The most important financial support for hospitals is compensation for revenue shortfalls related to postponement of non-essential surgery and treatments. Until September 2020, hospitals receive a per diem payment of €560 per day for every empty bed. In practice, hospitals receive a per diem-based lump sum, which is calculated by determining the difference between the number of patients currently being treated per day and the average number of patients treated in the previous year. A revision of the Act on 1st July, which introduced a system of tiered per diems (ranging between €360 and €760), where the amount depends on the hospital’s case mix index, the average length of stay in 2019 and the reporting of ICU capacities to the intensive care register.

To fund increased treatment capacities, hospitals receive a one-time payment of €50,000 for each additional ICU bed with ventilation capabilities that they set up in the period between 1 April and 30 September. In addition, Länder governments often top-up this payment to cover the full costs of creating a new ICU bed.

To cover additional expenditures related to COVID-19 hospitals receive a top-up payment of €50 for every patient who is admitted during the period between 1 April and 30 June to cover for the increased costs for PPE. Since 1st July, this amount has been increased to €100 and prolonged until 30th September.

Hospitals receive a higher daily nursing fee (an additional €38 per patient per day) to allow them to schedule for an increased level of nursing care.

These support measures are accompanied by several financial and administrative relief measures that aim to further secure the liquidity of hospitals. These include a reduced payment periods for Social Health Insurance funds, fewer billing audits, temporary audit exemptions for hospital treatments of COVID-19 patients and a new additional fee to finance COVID-19 tests performed in hospitals.

In England, where hospitals are usually paid on the basis of a DRG-like payment system with certain adjustments based on quality of care (P4Q – Pay for Quality), a radical decision was taken at the beginning of the pandemic that the normal payment system would be discontinued between April and July 2020. Instead, all hospitals have received a global budget based on the previous year’s average monthly expenditures plus an increase to account for inflation. The UK government has also taken a decision during COVID-19 to write-off £13.4 billion (about €14.9 billion) of historic debt of NHS trusts in England. In France, where the DRG-based payment system has remained in place, a guarantee was issued by the Ministry of Health in March 2020 that hospitals would receive additional payments to compensate any income loss when compared to their usual revenues. In Finland, the national government has made available €200 million, and (public) hospital owners can apply for funding to compensate for COVID-19 related deficits.

Other countries have made substantial resources available to hospitals through new payment approaches. In Germany, a new law was approved at the end of March guaranteeing that hospitals will receive per diem payments (€560 per day) for every empty bed until the end of September 2020 (see also Box 1). In Belgium, the federal authorities created a short-term cash advance to hospitals (of €1 billion), to compensate for revenue losses – and also to cover the extra costs of COVID-19 patients. However, a proposal currently suggests that the cash advance will be counted towards any further COVID-19-related hospital payment adjustments (e.g. an income guarantee, a budget for capacity expansion, and per diems for hospitalisations).

In Switzerland, financial compensation for the lost revenue resulting from the cancellation of elective admissions has depended on cantonal decisions, and some cantons were quicker to react and provided more generous compensation than others. In general, hospitals – in particular private ones – could apply for bridging credits and short-time work compensation just as any other business entity in the country making a loss and being at risk of job losses. If hospitals apply for short-time work, they can reduce their salary costs, and 80% of the difference between the current salary and the normal salary of their employees will be covered by the government.

Hospitals are paid for treating COVID-19 patients using the usual system, modified DRGs or new mechanisms

Figure 1 also provides an overview of payment systems used by different countries to pay for COVID-19 patients. Several countries have – at least initially – used their regular hospital payment system. In Bulgaria, hospitals are paid using a mix of case payment (based on an existing general case definition), per diems (for every day a patient is treated on an ICU). In Israel, hospitals were initially paid based on existing per diem codes for internal medicine wards and ICUs. However, since mid-April new per diem codes have been created for patients treated on dedicated COVID-19 wards of geriatric and general hospitals for moderately/severely ill COVID-19 patients (including with ventilation). These payments are excluded from the usual budget cap.
Box 2: Poland: Channelling new funding to hospitals, while protecting them from revenue loss

The central government is responsible for financing COVID-19-related hospital services. Funds are transferred (based on a monthly report) to the National Health Fund (NHF), which in turn uses them to pay for health services. The payments are made based on reports and bills submitted by providers to the NHF outside the usual contracts for providing health care services. Only providers included in the list of providers dedicated to performing services related to COVID-19, are entitled to receive these dedicated funds.

In order to pay for COVID-19 related services, the NHF has established a new reimbursement catalogue with prices. According to the catalogue, providers are paid lump sums for assuring readiness to provide services and FFS for the actual provision of services. Over time, the catalogue has been updated to reflect the changing needs of the population. Originally, it included six items such as hospitalisation, hospitalisation in an ICU, isolation in a designated facility, transport, readiness to provide hospitalisation, and readiness to provide transport. This list has been extended to 33 items, with some items split into more detailed procedures. Hospitals exclusively treating COVID-19 patients receive a lump sum and payment for each COVID-19 service provided, as well as funds for readiness to provide services.

Additional funds for health care services have been released by the NHF to cover extra costs without reducing regular payments to hospitals due to the cancellation of services not related to COVID-19. During the first months of the pandemic, hospitals in the public hospital network continued to receive their ‘usual’ monthly instalments, which had been increased by 5% at the beginning of the year. In addition, they received payments for services related to COVID-19, which could add up to substantial amounts if they treated many patients. For these hospitals, the regular lump sum payments have now been reduced. Hospitals outside the network could apply to receive payments for contracted services (in monthly instalments) under the assumption that they would provide these services later in the year. To secure financial liquidity of hospitals, payments are made faster and more frequently.

In France, Germany, Romania and Switzerland, where hospitals are paid using DRG-based payment systems, these systems had to be slightly modified to enable payment for patients with COVID-19. For example, coding guidelines for diagnoses and procedures were adjusted to enable hospitals to code for isolation treatment for patients with confirmed coronavirus. In addition, hospitals in Germany receive a top-up payment for every hospital case (including for non-COVID-19 patients) treated between 1 April and 30 September to cover the additional costs of PPE; and the average daily nursing fee was increased by €38 (see Box 1). In the Czech Republic, hospitals receive a new per-diem for COVID-19 positive patients (€2,237 per day for treatment in an ICU and €88 per day on other ward) in addition to their usual monthly instalments. In addition, the usual monthly instalments have been increased by about 1% in order to account for the additional costs of PPE.

In Belgium, where hospitals are usually paid based on a mix of global budgets, DRGs, and fee-for-service (FFS), new FFS billing codes have been created, e.g. for physicians treating COVID-19 patients, as well as for ICU care and for specialist services. In Poland, the National Health Fund has established a reimbursement list, which includes fees for hospitalisation, hospitalisation in an ICU, isolation in a designated facility, and lump sums for readiness to provide hospitalisation. Over time, the list has been extended to include 30 COVID-19-related fees for inpatient and outpatient care (see also Box 2). In England, providers were given the possibility to claim additional reasonable expenditures related to COVID-19, if the new global budgets did not equal actual costs (e.g. if additional staff had to be employed). Similarly, in Finland, the central government will compensate hospital districts (i.e. hospital owners) for additional costs related to the care of patients with COVID-19.

Concerning necessary investments, governments in several countries (e.g. the Czech Republic, England, Israel, Malta, Slovakia, Slovenia) have directly purchased ventilators, beds, and/or PPE and distributed these to hospitals – at least during the early stages of the pandemic. In Germany, hospitals received a lump sum payment of €50,000 for every new ICU bed set up to prepare for the expected influx of patients. In England, between 3 April and 19 May, NHS hospitals were allowed to make capital investments of up to £250,000 (€278,000) without requiring national pre-approval.

Only a few countries are paying non-contracted providers

Only relatively few countries seem to have put in place specific rules to pay for services provided by non-contracted (public and private) providers, either to increase capacity for treating COVID-19 patients or to compensate for reduced capacity in public hospitals, which are busy taking care of COVID-19 patients. For example, in England, the NHS made a block contract with the vast majority of private hospitals to make their capacity available for NHS patients, while being reimbursed for services provided based on the full costs of care. Similar agreements with the private sector were also concluded in Malta. In Cyprus, patients who could not be treated in public hospitals due to the closure of departments could be treated by private providers, and costs of care were reimbursed by the Ministry of Health through FFS payments at a slightly reduced rate (20% below usual private sector prices).
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In view of the ongoing challenges of COVID-19, all countries in Europe will have to find solutions to protect hospitals from revenue shortfalls and to adequately reimburse for COVID-19-related costs of care. A top priority should be for policymakers to minimise the impact of COVID-19 on regular service provision, e.g. by concentrating care for these patients at dedicated wards of designated providers. This may allow other hospitals to continue normal operations, thus avoiding the need to compensate revenue shortfalls. Of course, the easiest (short-term) solution to avoid revenue shortfalls is keeping existing hospital budgets intact. However, this also reduces the incentive for hospitals to restructure service delivery in line with new provision needs during the pandemic.

Concerning the reimbursement of COVID-19-related costs, all countries will likely need to adjust their hospital payment systems, e.g. by modifying DRG-based payments, increasing per diem rates, or adding additional fees to FFS systems. However, these payment adjustments would ideally accompany and support the concentration of care, e.g. by making the designation as a COVID-19 centre a prerequisite for receiving COVID-19-related payments like in Israel or Poland. In addition, given the risk of future pandemics, processes need to be put in place to rapidly adjust payment systems to meet new challenges where and when needed.

Conclusion

In addition to clinical and organisational challenges, COVID-19 has placed a significant burden on hospital finances. Although a complete overview of all countries currently remains unavailable, all of the countries included in this article have responded relatively quickly to find pragmatic solutions to evolving challenges. However, the adopted approaches differ considerably across countries. Germany stands out as having made substantial additional resources available to hospitals, both to pay for COVID-19 and to compensate for revenue shortfalls (see Box 1). Belgium has also responded very quickly to mobilise substantial additional resources for hospitals. Other countries, such as the Czech Republic and Poland continue to pay the usual monthly instalments to hospitals, which effectively compensates for revenue shortfalls in the short-term. England also stands out as a country that has taken the dramatic decision to discontinue its normal (DRG-based) payment system (at least during the pandemic) in favour of global budget allocations and cost-based reimbursement.

References